Shoudt & Reilly Psychological Services, LLC.

6720 E. Perkiomen Avenue, Birdsboro, PA 19508
Telephone #: 610-404-1726
Fax #: 610-404-1734

Client Information Questionnaire

(All information is confidential)

Date: _____

Name:_____ Date of Birth:_____

Emergency Contact:_____ Phone #:_____
Relationship:_____
_

Marital Status: ____Single ____Married ____Engaged ____Divorced ____Widowed
____Domestic Partnership ____ Seperated

Occupation:_____ Education:_____

Family Physician:_____ Date of last exam:_____

Who referred you so us:_____ Relationship:_____

List people who live in patient's home

Name	Age/Date of Birth	Relationship	Occupation
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

What is (are) the reason(s) for seeking treatment?

_____

_____

_____

_____

To help us understand better what concerns you may have, please circle any of the following problems which pertain to you:

Nervousness	Depression	Fears
Shyness	Sexual Problems	Suicidal Thoughts
Separation	Divorce	Finances
Drug Use	Alcohol Use	Friends
Anger	Self-Control	Unhappiness
Sleep	Stress	Work
Relaxation	Headaches	Tiredness
Legal Matters	Memory	Ambition
Energy	Insomnia	Making Decisions
Loneliness	Inferiority Feelings	Concentration
Education	Career Choices	Health Problems
Temper	Nightmares	Marriage
Children	Appetite	Stomach Trouble
Bowel Troubles	Parenting	Grief
My thoughts		

Cultural/Spiritual Issues

Some managed care companies require we ask the following questions regarding cultural/ spiritual issues. You may choose to respond or not respond.

1. With what ethnic/cultural/racial group to you identify?_____
2. What is your religious affiliation?_____
3. What role does your religion/spirituality play in your life?
   _____ Positive _____ Negative _____ Neutral
4. Are there any Spiritual or cultural issues that you feel need to be taken into account in your treatment? _____Yes _____ No (If yes, please explain)

_____
_____
_____

Treatment History

1. Have you ever received mental health or substance abuse treatment?
   ____ Inpatient ____Outpatient ____ None

Place/Provider:_____ Year(s):_____ Reason:_____

Place/Provider:_____ Year(s):_____ Reason:_____

Place/Provider:_____ Year(s):_____ Reason:_____

Place/Provider:_____ Year(s):_____ Reason:_____

Place/Provider:_____ Year(s):_____ Reason:_____

Place/Provider:_____ Year(s):_____ Reason:_____

2. When were you last seen by a mental health professional? _____ ___N/A

3. Are you currently taking medication for anxiety, depression, insomnia, etc.?
____ Yes ____ No
If Yes,

Drug	When	How Long	Effectiveness

4. Have you in the past taken medication for anxiety, depression, insomnia, etc.?

____ Yes ____ No
If Yes,

Drug	When	How Long	Effectiveness	Why Discontinued

5. Does anyone in your family have a history of mental illness, emotional difficulties, or substance abuse? _____ Yes _____ No

   Describe: _____

Medical History

1. Please list your family doctor and any other physicians or therapists involved in your care.

_____
_____
_____
_____

2. Do you have any health problems? _____ Yes _____ No
   List: _____ _____
_____ _____
_____ _____

3. Have you had any major, non-psychiatric hospitalizations? ____ Yes ____ No

If Yes,	Place	Year	Reason

4. Are you currently taking medication for a health problem.? ____ Yes ____ No
If Yes,

Drug	When	How Long	Effectiveness

5. Do you have any drug allergies or sensitivities? _____ Yes _____ No

Please list:

Drug Symptom

_____

_____

_____

6. Do you have any other allergies or sensitivities (e.g. environmental, food, dye, latex, etc.)?
   _____ Yes _____ No
   Describe: _____

_____

Do you have any family history of medical problems, including diabetes, heart disease, cancer, Alzheimer's, asthma, etc? _____ Yes _____ No
Describe: _____

_____

_____

Diet, Substance Use, Life Style Issues

1. Are you on a special Diet? _____ Yes _____ No
   Describe: _____

2. Current caffeine consumption (Soda, Coffee, Tea, Iced Tea, Etc)? ____ Yes ____ No
   Amount: _____

3. Do you take Over the Counter medications, herbal preparations, dietary supplements, etc.? _____ Yes _____ No
   Type: _____

4. Do you drink alcohol? _____ Yes _____ No
   Type: _____ Amount: _____ Last use:_____

5. Have you ever had a problem with alcohol? _____ Yes _____ No
   Describe: _____

6. Do you use any illicit drugs, e.g. marijuana, cocaine, hallucinogens, etc.? __Yes __No
   Type: _____ Amount: _____ Last use:_____

7. Do you use tobacco in any form? _____ Yes _____ No
   Describe: _____

8. Have you ever experienced unprotected sex, needle sharing, or blood transfusion?
   _____ Yes _____ No Describe: _____

Other

Is there any other pertinent information it is important for your clinician to know?

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CLIENT INFORMATION QUESTIONNAIRE

ALL INFORMATION CONFIDENTIAL

General Information Date: _____

Child's Name:_____ Age:_____ Sex: _____DOB:_____

Address:_____ City: _____ Zip:_____

Child's Legal Custodian: _____ Home Phone:_____

Name of person completing this form: _____

Relationship to child: _____

Referred by: _____ Phone:_____

Father's Name: _____Relationship if not biological: _____

Mother's Name: _____ Relationship if not biological: _____

Biological father's address (if not living with child):

_____

Phone Number: _____ Frequency of Contact:_____

Biological mother's address (if not living with child):

_____

Phone Number: _____ Frequency of Contact:_____

Please list name & address of your child's primary care physician & any other physicians involved in their care:_____

_____

_____

List family members & all others in the home:
Name: Age Relationship Occupation

Describe how you feel your child relates to the rest of the family:

If parents are divorced/separated, how old was child at time of separation?

List any other siblings (along with age & relationship) not in the home:

Please describe your child's current medical, behaviors and emotional problems. Include age at which problems started and any recent stressors:

What seems to help?

Circle any of the following if they have been problems for your child:

Speech or language	Fearful	Slow learner
Coordination	Wets bed	Sad
Prefers to be alone	Bites nails	Stomach troubles
Fights w/ siblings	Sucks thumb	Angry
Fights w/ peers	Tantrums	Can't relax
Fights w/ adults	Nightmares	Lonely
Physically aggressive	Sleep	Feels inferior
Destroys property	Rocking	Suicidal Thoughts
Cruel to animals	Head banging	Trouble w/ friends
Steals	Holds breathe	Indecisive
Shy/timid	Poor appetite	Depressed
Reckless behaviors	Stubborn/willful	Nervous
Self injury	Overactive	Bowel Problems
Odd habits/mannerisms	Impulsive	Obsessive
Lack of friends	Frequent visits to nurse	Frequent visits to Guidance office

Developmental History:

Age of mother during pregnancy _____ Mother's health: ⇨ good ⇨ fair ⇨ poor

List medications during pregnancy

_____

Did mother smoke, drink alcohol or use substances during pregnancy?

_____

Specify amounts, types and frequency

_____

_____

_____

Any illness during or complications of pregnancy?

_____

Length of pregnancy _____weeks Labor _____hours

Birth Weight _____ Type of Delivery ⇨ vaginal ⇨ C-section

Any instruments/forceps? (Specify)

_____

Any complications of delivery or birth defects?

_____

Was mother depressed or down after delivery?

_____

Please describe child as an infant: ⇨ pleasant ⇨ fussy ⇨ calm ⇨ colicky
⇨ irritable ⇨hard to manage

Any problems with sleep or feeding (describe)

_____

_____

Developmental Milestones:

To the best of your recollection, please fill in the age at which your child began each of these behaviors:
(If you cannot remember ages, specify if the event was early, on time, or late)

Showed response to parent _____ Put several words together _____

Rolled over _____ Dressed self _____

Sat alone _____ Toilet trained: Bladder _____ Bowel _____

Crawled _____ Dry at night _____

Walked alone _____ Fed self _____

Babbled _____ Rode tricycle _____

Spoke single words _____

Have there been any caregivers other than parent prior to kindergarten?

Age Setting Child's reactions/behavior

_____

_____

_____

_____

_

Medical History:

Please circle any of the following conditions your child has had & list age of occurrence

Measles _____ Whooping Cough _____

German measles _____ Meningitis _____

Mumps _____ Encephalitis _____

Chicken pox _____ Seizures _____

Rheumatic fever _____ Head injury _____

Broken bones _____ Diabetes _____

Visual problems _____ Cancer _____

Hearing problems _____ Bleeding problems _____

Paralysis _____ Frequent nosebleeds _____

Severe/frequent headaches _____ Skin conditions _____

Extreme fatigue _____ Suicide attempt _____

Anemia _____ Bowel problems _____

Memory problems _____ Eating problems _____

Tuberculosis _____ Loss of consciousness _____

Fever above 105 _____ Dizziness/fainting _____

Is your child on a special diet? ⇨ No ⇨ Yes
Describe _____

Does your child take any medications currently? ⇨ No ⇨ Yes
Please include any over the counter medications, herbal supplements or remedies.

Drug Dose Frequency Duration Reason Prescribed by

_____
_____
_____
_____
____

In the past, has your child ever been on medication for anxiety, depression, behavior problems, etc.?

Drug Dose Frequency Effectiveness Side Effects Why discontinued

_____
_____
_____
___

Does your child have any drug allergies or sensitivities? ⇨ No ⇨ Yes

Drug Symptoms

_____
_____

Does your child have any other allergies or sensitivities (environmental, food, dye, latex, etc.)?
⇨ No ⇨ Yes, describe _____

Caffeine consumption: (soda, tea, iced tea, coffee, etc.) amount _____ per day/week

Sexual Development:

Has your child started developing sexual characteristics such as pubic hair or breast change?
⇨ No ⇨ Yes

If yes, at what age & what was your child's attitude toward this?

_____

_____

__

If applicable, age at first menstruation: _____

Any menstrual irregularities, cramps or other physical discomfort? ⇨ No ⇨ Yes

Psychiatric History:

Has your child ever received any mental health and/or substance abuse treatment?

⇨ No ⇨ In-patient ⇨ Out-patient

Place/Provider Dates Reason Outcome

_____

_____

_____

___

When was your child last seen by a mental health professional?

_____

Significant Events – please check & describe:

Event Date Describe

Loss of someone close

_____

Loss of pet

_____

Trouble with the law

_____

Living/placement away from home

_____

Incest/sexual abuse

_____

Physical abuse or neglect

_____

Emotional abuse

_____

Held back in school

_____

Moves

_____

Significant health problems of

_____

self or family member

Child's Education Grade _____

Name and address of school child presently attends:

_____ Phone:

_____

_____ Contact person:

_____

Please check what you feel describes your child in the following areas:

Attendance: ⇨ Rarely absent ⇨ Sometimes absent ⇨ Often absent

Ability: ⇨ Above average ⇨ Average ⇨ Below average

Relationship with peers: ⇨ Above average ⇨ Average ⇨ Below Average

Behavior: ⇨ Above average ⇨ Average ⇨ Below average

Has your child ever been suspended or expelled? ⇨ No ⇨ Yes

If yes, describe

_____

Any difficulty with: ⇨ Reading ⇨ Math ⇨ Spelling ⇨ Writing
Other_____

What, if any, special services have been provided for your child in school (speech/language, remedial reading, special classes, counseling, groups, occupational therapy)?

_____
_____
_____
_____

Does your child have an IEP? ⇨ No ⇨ Yes

Any school refusal or avoidance? ⇨ No ⇨ Yes

Social/Extracurricular activities (list & comment):

_____
_____
_____
_____
_____

Family History:

Is there a family history of any of the following disorders – if so, please check and list family members on adjacent line:

⇨Depression_____
__
⇨Manic-Depression
_____
⇨Anxiety
Disorders_____
⇨Suicide Attempt
_____
⇨Autism
_____
⇨Attention
Deficit/Hyperactivity_____
⇨Tics
_____
⇨Learning Disorders
_____
⇨Mental Retardation
_____

⇨Alcoholism

_____

⇨Drug Abuse

_____

Any family history of medical problems, including diabetes, heart disease, cancer, seizures, Alzheimer's, asthma, etc.? ⇨No ⇨Yes
Describe

_____

_____

_____

Parents' current marital status:

⇨ Married & living together ⇨ Separated ⇨ Widowed ⇨ Mother remarried
⇨ Single, never married ⇨ Divorced ⇨ Living together ⇨ Father remarried

How would you describe the relationship between you and your child's co-parent?

⇨ No difficulties ⇨ Occasional difficulties ⇨ Frequent difficulties

Describe significant marital problems and how both spouses view them:

Mother's View:

_____

_____

_____

Father's View:

_____

_____

_____

Any marital counseling? ⇨ No ⇨Yes

Parent's History:

Biological Mother:
Name: _____ Age: _____
Highest Level of Education:
_____
Please describe any problems growing up – particularly those involving relationships/family:
_____
_____
_____
_____

Biological Father:
Name: _____ Age: _____
Highest Level of Education:
_____
Please describe any problems growing up – particularly those involving relationships/family:
_____
_____
_____
_____

Adoptive or Stepmother:
Name: _____ Age: _____
Occupation: _____ Highest Level of Education:
_____
Please describe any problems growing up – particularly those involving relationships/family:
_____
_____
_____
___
How did this child adjust to his/her stepmother?
_____
_____
_____
_____

Adoptive or Stepfather:
Name: _____ Age: _____
Occupation: _____ Highest Level of Education:
_____
Please describe any problems growing up – particularly those involving relationships/family:
_____
_____
_____
_____

How did this child adjust to his/her stepfather?

_____
_____
_____
_____

Optional:

Some managed care companies require we ask the following questions regarding cultural/spiritual issues. You may choose to respond or not respond.
With what ethnic/cultural /racial group do you identify?

_____
What is your religious affiliation?

_____
What role does your religion/spirituality play in your life?

_____
_____
__
Are there any spiritual or cultural issues that you feel need to be taken into account in your child's treatment? ⇨No ⇨Yes, Please explain

_____
_____
_

Please list any additional comments or concerns:

_____
_____
_____
_____
_____
_____
_____
_____
_____

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OUTPATIENT SERVICES CONTRACT

Welcome to Shoudt & Reilly Psychological Services, LLC. Since this is your first visit, we hope what is written here can answer some of your questions as you seek therapy. Please let us know if you want clarification on any of the topics discussed in this Outpatient Services Contract, or if you have any questions that are not addressed here. When you sign this document, you are stating that you understand and will adhere to the information in this Outpatient Services Contract.

PSYCHOTHERAPY SERVICES

We provide psychotherapy services for children, adolescents, adults, couples and families. The first appointment(s) serves as a intake appointment. We will want to hear about the difficulties that led to you making an appointment, goals for therapy, and general information about yourself and your current life situation. By the end of this first appointment, we will give you some initial recommendations on what we think will help. If we do not think we are able to best assist you, we will give you names of other professionals who we believe would work well with your particular issues. If you do not agree with our treatment recommendations or do not think our personality styles will be a good match for you, let us know and we will do our best to suggest a different therapist who may be a better fit.

If you and your therapist decide to work together in therapy, you will collaborate on a treatment plan that incorporates effective strategies to help with whatever difficulties you are hoping to reduce in therapy. Sometimes more than one approach is helpful. Individual, couples and family therapy sessions last 45-60 minutes unless otherwise arranged. The frequency of sessions will be determined after the initial evaluation and agreed upon by you and your clinician.

Therapy can be extremely helpful and fulfilling, and it takes work both in and out of sessions to be most effective. It requires active involvement, honesty, and openness in order to change thoughts, emotional reactions and/or behaviors. There are benefits and risks to therapy. Potential benefits include increased healthy habits, improved communication and stability in relationships, and lessening of distress. Some potential risks include increased uncomfortable emotions as you self-explore, and changes in dynamics or communication with significant people in your life. Sometimes couples that come for therapy choose to end their relationships. Although there are many benefits to therapy, there is no guarantee of positive or intended results. If during your work together with your therapist, noncompliance with treatment recommendations becomes an issue, we will make an effort to discuss this with you to determine the barriers to treatment compliance. At times, treatment noncompliance may necessitate termination of therapy service. We encourage you to discuss any concerns you have about our work together directly so that we can address it in a timely manner. Other factors that may result in termination of therapy include, but are not limited to, violence or threats toward us, or refusal to pay for services after a reasonable time and attempts to resolve the issue.

Deciding when therapy is complete is meant to be a mutual decision, and we will discuss how to know when therapy is nearing completion. Sometimes people begin to schedule less frequently to gradually end therapy. Others feel ready to end therapy without a phasing out period of time. We may at times seek consultation with other therapists to ensure we are helping you in the most effective manner. We will give information only to the extent necessary, and we make every effort to avoid revealing the identity of clients. The clinician is also under a legal and ethical duty to keep the information confidential

AVAILABILITY BETWEEN SESSIONS

If needed, you can leave your clinician a message on our 24-hour voicemail box at 610-404-1726, and their extension. When you leave a message, include your telephone number even if you think we already have it, and best times to reach you. We make every effort to return calls in a timely manner. In the rare occurrence that a message is missed or accidentally deleted, if you do not hear back from us within two business days, please leave a second message. If we are unavailable for an extended time, such as on vacation, we will inform you of the contact information for the therapist on-call during our absence.

If you have a truly urgent matter, you can call our answering service at 610-607-1751 and your clinician will be contacted.

If you are in an emergency situation and cannot wait for us to return your call, go to the nearest emergency room or call 911. Shoudt & Reilly Psychological Services, LLC is not a crisis facility. Do not contact us by email or fax in an emergency, as we may not get the information quickly.

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RATES AND INSURANCE

Therapy is a commitment of time, energy and financial resources. If you have health insurance, it is important for you to verify your mental health benefits so you understand your coverage prior to your appointment. Some insurance companies require a pre-certification before the first appointment or they will not cover the cost of services.
Our current fees are as follows:

- Initial Intake Appointment: $185 ($95 for resident)
- Psychotherapy Sessions: $150.00 ($95 for resident)
- Patients with insurance: the negotiated rate with each insurance company
- Copy of records: $25
- Letters and communications to other providers: $25
- Insurance company appeals, lengthy claims forms/reports: $25
- Telephone Consult: $25 per 10 minutes
- School/IEP Meetings: $150 per hour
- No show or cancelation less then 24 hours: $75
- Re-bill charge for payments not received within 30 days: $5

These fees are reviewed annually and are subject to change with written notice.

We also provide telephone and online therapy sessions under certain circumstances. Some health insurance carriers cover Tele-health (online therapy). If your insurance plan does not cover Tele-health, it is your responsibility to pay our full rate for the therapy session.

We are happy to assist you by having our Billing Manager file claims to your insurance company on your behalf. However, you, not your insurance company, are responsible for payment of the fee for therapy. Acceptable forms of payment include cash, check and major credit cards, and payment is expected at the time of service. **Cancellations or missed appointments without 24 hours notice will be subject to the cancelation fee, and insurance companies do not pay charges for missed appointments.** If fees for services are not paid in a reasonable amount of time, and attempts have been made to resolve the financial matter to no avail, a client account may be sent to a collection service.

It is your responsibility to check insurance benefit. There are times when insurance misquotes benefits. In the event of a misquote, clients are still responsible for their copay/ coinsurance/deductible amount that insurance reports after claims are submitted.

Most insurance agreements require you to authorize us to provide a clinical diagnosis and sometimes additional clinical information. If you request it, we will provide you with information to send to your insurance company. This information will become part of the insurance company's files. Insurance companies claim to keep information confidential, but

you should check with your insurance company directly if you have questions about their confidentiality practices.

TELE-HEALTH

There may be instances where in office sessions are not feasible. Tele-health may then be an option to be discussed with your clinician. You are responsible to check your insurance coverage for tele-health and are responsible for any payment that is not covered. The clinicians at Shoudt & Reilly Psychological Services use a HIPPA compliant tele-health platform. An additional consent for tele-health services is required.

SOCIAL MEDIA

In order to maintain your confidentiality and our respective privacy, we do not interact with current or former clients on social networking websites. We do not accept friend or contact requests from current of former clients on any social networking sites including Twitter, Facebook, LinkedIn, Instagram, Tik Tok, etc. We will not respond to friend requests or messages through these sites.

We will not solicit testimonials, ratings or grades from clients on websites or through any means. We will not respond to testimonials, ratings or grades on websites, whether positive or negative, in order to maintain your confidentiality. Our hope is that you will bring concerns about our work together to the therapy session so we can address concerns directly.

Please do not contact us through text messages or emails regarding clinical issues. These are not secure communications, and there is a possibility that we will not get the message in a timely manner, or that communication will be interpreted in an unclear manner. If you need to contact your therapist between sessions, please call 610-404-1726..

PROFESSIONAL RECORDS

Both law and the standards of our profession require that we keep appropriate treatment records. If we receive a request for information about you, you must authorize in writing that you agree that the requested information released.

CONFIDENTIALITY

In general, law protects the confidentiality of all communications between a client and a mental health clinician, and we can only release information to others with your written permission. However, there are a number of exceptions, which are indicated below. More information is provided about this in your HIPAA statement.

In judicial proceedings, if a judge orders the records released, we have to release the records. In addition, we are ethically and legally required to take action to protect others from harm

even if taking this action means we reveal information about you. For example, if we believe a child, elderly person or disabled person is being abused or neglected, we are mandated to report this to the appropriate state agency. If we believe a client is threatening serious harm to another person or property, we must take protective action (through notifying the potential victim, the police, and/or facilitating hospitalization of my client). If we believe a client is a serious threat to harming him/ herself, we must take protective action (arranging hospitalization, contacting family/ significant others for notification, and/ or contacting the police). We would make reasonable effort to discuss any need to disclose confidential information about you, and we are happy to answer any questions you have about the exceptions to confidentiality.

MINORS

If you are under 14 years of age, please be aware that the law may provide your parents the right to examine your treatment records. If you are between the ages of 14 and 18, the law may provide your parents the right to examine your treatment records if after being informed of your parents' request to examine your records, you do not object or your therapist does not find that there are compelling reasons for denying the access to the records. Notwithstanding the above, your parents are always entitled to the following information: current physical and mental condition, diagnosis, treatment needs, services provided, and services needed. Before giving them any information, your therapist will discuss the matter with you, if possible, and do their best to handle any objections you may have with what is prepared to discuss.

COURT RELATED SERVICES

We do not provide or perform evaluations for custody, visitation or other forensic matters. Therefore, it is understood and agreed that we will not provide any testimony or reports regarding issues of custody, visitation or fitness of a parent in any legal matters or administrative proceedings. This policy is based on both ethical and clinical decisions. It is not in the best interest of our patient, your child for us to be involved in legal proceedings. Doing this would constitute a dual relationship with your child that could potentially damage the therapeutic relationship.

In regards to custody evaluations, it is in each parent's best interest and your child's best interest that evaluations and opinions be given by an independent evaluator. This professional can either be court appointed or your child's clinician may be able to make recommendations.

COMPLAINTS

If you have a concern or complaint about your treatment or about your billing statement, please talk to us about it. We will take your criticism seriously, openly, and respond respectfully.

QUESTIONS

If during the course of your therapy, you have any questions about the nature of your therapy or about your billing statement, please ask.

A FINAL WORD

The counseling relationship is a very personal and individualized partnership. We want to know what you find helpful and what, if anything, may be getting in the way. We want you to feel free to share with us what we can do to help.

YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

YOUR RIGHTS	YOUR CHOICES	OUR USES AND DISCLOSURES
Your have the right to: ▪ Get a copy of your paper or electronic medical record ▪ Correct your paper or electronic medical record ▪ Request confidential communication ▪ Ask us to limit the information we share ▪ Get a list of those with whom we've shared your information ▪ Get a copy of this privacy notice ▪ Choose someone to act for you ▪ File a complaint if you believe your privacy rights have been violated	You have some choices in the way that we use and share information as we: ▪ Tell family and friends about your condition ▪ Provide disaster relief ▪ Provide mental health care	We may use and share your information as we: • Treat you • Run our organization • Bill for your services • Help with public health and safety issues • Do research • Comply with the law • Work with a medical examiner or funeral director • Address workers' compensation, law enforcement, and other government requests • Respond to lawsuits and legal actions

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Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

Shoudt & Reilly Psychological Services, LLC
6720 Perkiomen Ave
Birdsboro, PA 19508
610-404-1726
610-404-1734 (fax)
ShoudtReillyPsychologicalServices.com

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

- **Treat you**

We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

- **Run our organization**

We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services.

- **Bill for your services**

We can use and share your health information to bill and get payment from health plans or other entities.
Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official

- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

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Outpatient Services Contract

Please ask before signing below if you have any questions about psychotherapy or our office policies. Your signature indicates that you have read our Outpatient Services Contract and agree to enter therapy under these conditions. Your signature below indicates that you are making an informed choice to consent to therapy and understand and accept the terms of this agreement.

I have read and agree to the terms in the outpatient services contract

(pages 1-5).

Client Name:

_____ Client

Signature: _____ Date: _____

Guardian Signature (if minor): _____ Date:

_____

Guardian Signature (if minor): _____ Date:

_____

Notice of Privacy Practices

I have read the notice of privacy section (pages 6-9).

Client Name: _____

Client Signature: _____ Date: _____

Guardian Signature (if minor): _____ Date:

_____

Guardian Signature (if minor): _____ Date: _____

Demographic Information

Client Legal Name:	Date:
Client Preferred Name:	Preferred Pronouns:
Legal Sex: M F *While Shoudt & Reilly Psychological Services, LLC recognizes a number of genders / sexes, many insurance companies do not. Please be aware that your legal name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing and correspondence. If your preferred name and pronouns are different from these, please let us know.	
DOB:	Email:
Client Address:	
Best number to reach you:	May we leave a message? Yes No
Policy Holder Name:	DOB:
Relationship to client:	

Emergency Contact/Guardian Information

Name:	Relationship to client:
Address:	Phone Number:

Additional Information

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What are your presenting issues?
How were you referred to Shoudt & Reilly Psychological Services?
Please list any medications/doses:

AUTHORIZATION FOR RELEASE OF MENTAL HEALTH, ALCOHOL & DRUG ABUSE, AND OTHER PERSONAL HEALTH INFORMATION

I, _____ hereby authorize _____
(Patient/Parent/Guardian/Power of Attorney) (Facility/Therapist/Counselor)

to exchange/release any and all records or information regarding
_____
(Name of Patient)

The following items must be **checked and initialed** to be included in the use and/or disclosure of other health information:

HIV/AIDS related treatment Mental health information Psychotherapy notes

Sexually transmitted diseases Drug/alcohol diagnosis, treatment/referral

to _____
(receiving Agency/person) (Address)

for the purpose of (please check all that apply):

Continuing (health and mental health) treatment or care and continuity of care Therapist transition

Billing, payment and financial matters and arrangements Consultation, advise and representation

Housing or other arrangements and services Other _____

This consent is valid until (calendar date)_____

I understand that I have the right to inspect and copy the information to be disclosed and may revoke this authorization at any time. Any such revocation will not affect materials disclosed prior to the revocation. The above-named person authorized to receive this information may use the information only for the purposes outlined above and may not redisclosed it without my written authorization.

I also understand that if I refuse to consent to this release of information the following may occur
_____

_____ _____
(Minor recipient, 14-17 yrs. Inclusive) (Signature of adult patient or parent)

_____
(Witness)

NOTICE TO PATIENT AND RECEIVING AGENCY:

Under the provisions of the Illinois Mental Health and Developmental Disabilities Confidentiality Act, HIPAA, and applicable Federal and State Alcohol and Substance Abuse Confidentiality Acts, there may not be re-disclosure of any of the information provided pursuant to this release unless the patient, and/or parent of the patient who is a minor, specifically authorizes such disclosure. A separate release is required for psychotherapy notes.

REVOCATION OF AUTHORIZATION

The undersigned hereby revokes the above authorization for disclosure.

_____ _____
(Patient, parent, guardian) (Witness)

_____ _____
(Authorized agent - Power of attorney attached) (Date)

CREDIT CARD ON FILE

Payments are due at the time of service. Shoudt & Reilly Psychological Services, LLC requires a credit, debit, or flex spending/HSA card on file in order to schedule sessions. The credit card on file can be used in order to pay for any copays, co-insurance, deductibles, no shows/ late cancellations or out of pocket payments if no other payment method is used at the time of the session or if a late cancellation or no show is incurred (in which case, the credit card on file will be charged the no show/cancelation fee on the day of scheduled session). Clients may also pay by cash or check at each session. Your credit card will be stored in a HIPAA compliant electronic health system and this document will be safely destroyed.
_____(initial)

Please check the box and sign below:

Please charge my card for charges in full for sessions at the time of service.

Client Name:	
Cardholder Name:	
Credit Card Number:	
Expiration Date:	Billing Zip Code of Credit Card:
Cardholder's Signature:	

I understand that by signing above, I am authorizing Shoudt & Reilly Psychological Services, LLC to charge my card in the manner indicated by my initials above. These balances may include co-pays, co-insurance amounts, out of pocket payments, deductibles, no show or late cancel fees.